POLITICS OF COST CONTROL ABROAD*

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COST-CONTAINMENT policies under national health insurance in foreign countries have gone through several distinct stages. At first, every country in Europe and in Canada experienced a period of starting national health insurance. This occurred at various times: in Germany during the 1880s, in several other countries between the wars, in others just as World War II ended. It was introduced for several reasons. Nonprofit sick funds had existed before, and the new statutes obligated coverage. Premiums or taxes stabilized financing of the funds. Organizations' collection problems eased and their memberships became larger and more predictable. National health insurance was also designed to cover many people who were not reached by nonprofit carriers. Benefit coverage was made more complete by the more sweeping coverage of the statute, in contrast to the varying benefits under different nonprofit carriers. Patients' out-of-pocket payments were reduced by the stronger financial base. The thrust during those years increased public and private spending in an underfinanced sector.

From the start under national health insurance, foreign countries had techniques to control costs. One element was prospective reimbursement of doctors, always paid by fee schedules negotiated between medical associations and the sick funds. Fee schedules were always taken for granted abroad under both nonprofit health insurance and national health insurance, in contrast to the resistance in the United States.

Another cost-containment technique in place from the start was prospective reimbursement of hospitals. Just as sick funds and public authorities never expected doctors to charge modestly, they assumed that more than the hospital's own self-restraint was necessary to decide how

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much to give them. A common technique throughout Europe was to calculate the average daily rate per patient in the hospital as a whole or in each service, and then to charge the sick funds according to the number of days spent by their subscribers in that hospital. While fee schedules were negotiated between medical associations and sick funds, organizing the many diversely owned hospitals into a single bargaining unit was more difficult. Public intervention was required: daily rates were regulated by a government agency, usually regional or provincial. In some countries, however, associations of hospitals gradually engaged in preliminary bargaining with sick funds or to petition regulatory agencies. Prospective reimbursement of hospitals has always been taken for granted abroad, although Americans "discovered" it only with the rise of state commissions during the 1970s.

Another important cost-containment method abroad almost from the start of national health insurance was control over capital expenditures by provincial or regional government. Even for nonprofit, privately owned hospitals, most capital comes from government rather than from a private capital market. This is quite different from the United States, with its private capital market even for health services and, therefore, its convoluted system of controls over capital expenditures, such as certificates of need. In most important capital expenditures in Europe and Canada, government can decide directly whether a hospital should expand or rebuild and therefore incur higher running costs in the future: government simply decides to give or not to give the money to the hospital.

Another technique from the start is cost-sharing by patients. Nearly every country charges for drugs and prostheses: it is believed that, otherwise, materials would be wasted. (One of the few countries without prescription charges, Japan, has enormous and probably excessive drug spending under national health insurance). Some countries have had a tradition of moderate cost-sharing for ambulatory care by patients. It is believed that such charges moderate unnecessary visits, but their principal importance seems to be an additional way to earn money for the health accounts. Other countries have no cost-sharing for ambulatory and hospital care. Whether or not there is cost-sharing is a fundamental decision made at the time of enacting national health insurance and frozen forever after.

THE BOOM

By the early 1950s every country had national health insurance—except

for the United States. (Parenthetically, in this article I describe only the cost trends and cost control techniques under national health insurance. I do not discuss the administration of a national health service such as Britain's or Sweden's.) During the 1950s and 1960s health care expanded greatly in services and costs in all countries. People were encouraged to go to hospitals and doctors, and utilization increased. Hospitals and doctors' offices modernized and expanded. The technological improvements initiated by the United States and Germany spread everywhere, as did extra costs from buying and operating the new methods. Medical and nursing staffs in hospitals grew in numbers.

Wages and hours changed in hospitals. Nurses and auxiliaries caught up with the wages and hours of equivalent people in comparable occupations. Nurses on salary for limited numbers of hours replaced nuns who worked all the time for hardly anything. Young doctors insisted on normal salaries matching their peers in elite occupations. They were paid in full for overtime work and for waiting time. Euphoric reforms changed the senior hospital physicians in many countries from part-timers with large outside practices to full-time salaried positions, but the chiefs insisted on huge salaries equal to their private practice earnings, thereby preserving their positions at the top of their countries' income scales.

To preserve general practice, every country raised the status of the general practitioner under the fee schedules. They received great increases in fees and incomes, and earned almost as much as the specialists. General practice survived, but at high costs.

No one opposed this boom in health spending at first. Trade unions and the political parties on the left had always pressed for the best care for their members as an article of faith, and were gratified by such lavish services. Providers of health care were delighted and pressed for more. Medical associations and hospital physicians prospered. Nurses and other hospital employees became unionized and militant, and the general trade union movement supported their demands. Community groups took pride in local hospitals and pressed government and the sick funds for ever more money and more lavish institutions. Charitable associations that owned hospitals (such as Caritas) welcomed the inflow of money and (as in the United States) assumed the mentalities of providers instead of almoners.

Early Misgivings

The first signs of apprehension about health-care costs abroad during the

1950s and 1960s came from ministries of finance, always critical of spending ministries. In those years they were the only group in the health-care game who thought about future trends in income and expenditure. Everyone else was naively optimistic. But ministries of finance foresaw a steady rise in payroll taxes and pressure on the national treasury to subsidize sick funds.

Federations of big business in a few countries began to worry, such as the French and Germans. Under their national health insurance laws, they had to pay large proportions of the payroll taxes that went to the sick funds and into disability benefits, and they feared a steadily larger burden. They grumbled about a big public spending program on ideological grounds. Big businessmen—even in countries with national health insurance—personally relied on private health insurance and looked on insurance only as a financial drain. At first, big business had only a traditional conservative response: restore private health insurance and patient cost-sharing, and reduce the role of government instead of expanding it by increasing its power to control health-care costs.

The Worldwide Cost Control Crisis

Suddenly every country during the early 1970s panicked over the cost of health. Everywhere it seemed to be rising faster than gross national product. Any sort of rapid social security expenditure rise was now seen as a severe problem because the declining birth rate in all developed countries meant that the workers, who earned the payroll taxes, were increasing more slowly than the elderly, who were incurring the bills. In a short time after World War II, several countries quickly faced the paradox of a contracting labor force at the same time as a much longer life expectancy produced a great increase in health-care users. Payroll taxes became very high, went up every year or two, and clearly were approaching a ceiling. Now the public and the trade unions—not merely the economists in the ministries of finance—complained.

Pressures were exerted on the treasury to subsidize the sick funds. As a stopgap, some countries "borrowed" money from the parts of social security that ran surpluses, such as family allowances, but that could not be a permanent solution. Subsidies from general revenue to the supposedly self-sustaining sick funds were made in some countries, but this had limits. Americans have long been accustomed to running deficits and printing money, but other developed countries try to balance their budgets.

Health care costs—and other inflation occurring at the same time—damaged countries' international positions. Exchange rates fluctuated violently. Inflation damaged their export markets. During the 1970s in all developed countries a big push for controlling health-care costs came from government. As in the American cost-containment efforts over Medicare, Medicaid, and hospitals during the 1970s, the powerful political constituency for health cost containment was government. But, in addition, another important pressure for cost control came from the sick funds, which were actually on the front line, paying out money. They and their sponsors, the trade unions and the political parties on the left, called for action against medical associations, hospitals, and other providers. In the United States, the nonprofit and commercial sick funds moved into this adversarial and cost-controlling position only gradually, and today still hesitate to assault the providers all-out.

Health care cost containment abroad during the 1970s encountered some political obstacles. No one wants to cut benefits, or, in actuality, no one wants to take the blame for reducing reimbursement for any benefit and telling the public to pay for all or part of it personally. Such a risky political gamble courts electoral defeat by the subscribing public. Cuts in payments or tighter controls over utilization cause uproars by doctors and by trade unions, and governments prefer not to court trouble. During the 1970s most governments prefer not to court trouble. During the 1970s most governments in Europe and Canada have been weak coalitions, and they often find it hard to develop the internal consensus to make very hard decisions. It is very difficult to control utilization or repeal entitlements under national health insurance because most statutes commit the sick funds and the government to provide benefits without limit to whoever "needs" them.

Attempts to Control Costs

First, traditional methods of cost control have been applied and perfected, either by the sick funds or by government or by both. The traditional method of bargaining with doctors over fees has been utilized more strictly. Sick funds have become much tougher adversaries. Medical associations have become weaker because they lost the political alliances they long enjoyed with businessmen's associations and with conservative political parties during the 1960s and earlier. Doctors often protest and threaten to emigrate in large numbers, but so far there have been virtually

no strikes and hardly any emigration beyond normal rates. The doctors' demands for much more money and the sick funds' offers of hardly any have been compromised by increasing use of formulas. They tie the annual increase in fees to the cost of living or to gross national product to prevent doctors' incomes from rising much faster than those of the rest of the country.

The traditional techniques of utilization review have been modernized by computer. Joint committees of doctors and sick funds—or other review committees—have become better at identifying individual doctors who bill much more than their peers, and bolder in questioning them. Capital expenditure controls over hospitals have been tightened. Several countries have terminated lavish programs of grants to their hospitals in general. Instead of such large sums of unrestricted money and across-the-board offers, capital spending has become more selective.

New Methods of Controlling Costs

Hospital cost control is in flux in nearly every country. The traditional method of an average daily rate for every patient is thought to prolong stays and to encourage waste because hospitals earn larger profits with each successive day. Some caps have been imposed as short-run stopgaps, such as allowing all of Ontario's hospitals to earn only 4.5% more during 1979 than during 1978. Therefore, Ontario now enforces a more draconian version of the Carter Administration's stillborn proposal to control American hospital costs. Many countries now experiment with techniques of budget review, with each hospital budget reviewed by a provincial or regional government agency. The ferment for new methods of budget review abroad parallels the search in the United States, but foreign countries are more likely to avoid complicated formulas as too difficult to administer and too susceptible to dispute.

Several countries now seek more flexible financing of health delivery to motivate more out-of-hospital treatment. The federal government of Canada converted its federal-provincial shared cost programs in hospitalization and medical care into entirely provincial programs to enable the provinces to finance care in any way they choose. Several European countries, such as France, now experiment with a variety of extramural programs.

As in the United States, attempts are made to undo the expansion of hospitals that occurred during the euphoric periods after World War II.

Beds are being shut in Ontario, Germany, Great Britain, and elsewhere. By starving privately owned hospitals through rate review, France also tries to cut beds. Governments in Europe and Canada—as well as in the United States—are discovering that reduction of beds requires skin thick enough to take the political heat from trade unions and neighborhoods.

Having used bilateral bargaining between providers and sick funds for many years, Germany tried to convert this negotiating style into a method to generate guidelines about health spending for the system as a whole. All the principal players in the health-expenditure game come together in a national forum twice a year, viz., the medical association, the hospital association, the dental association, the pharmaceutical association, the sick funds, business representatives, trade unions, and others. They agree on the desirable increase in expenditures for the next year, and the bargainers in practice implement the guidelines. The same scheme has been proposed in Holland, but nothing like it yet exists in the United States.

Pitfalls in Controlling Costs

Some political systems can make decisions more easily than others. Parliamentary systems are geared to make decisions in a limited time. If the ministry of finance decides there is a problem of controlling costs, something usually will be enacted. Political bargaining takes place, of course. Depending on the balance of power among interest groups in the country and the political strength of the cabinet, certain concessions are made on some topics, and the ultimate result may be much less tough than the preferences of the economists in finance. But something is enacted.

Throughout the history of the United States, the national government has had recurrent problems in making decisions. In some cases prosperity is ensured by the vigor of the private sector, or events in the private sector develop cyclically, so that eventually it revives by itself. However, when the national government has had weak leadership, some problems got steadily worse, with serious outcomes, such as the Civil War. The United States seems to be undergoing one of its periods of weak leadership and disorganized decision making of late, while a problem as serious as health-care cost containment exists. Recurrent inability to act on this much discussed subject breeds confusion and cynicism, in addition to the waste of money by itself. Therefore, one pitfall surrounding health costs is that the problem is serious enough that government must exhibit some capacity to deal with it or be discredited. Delay makes things worse.

Another pitfall is how to decide whether government or private bargainers have succeeded in controlling costs properly. When have they gone "too far" in cutting services and benefits? For example, the caps over hospital expenditures in Ontario and New York State satisfy the officials. But hospitals claim their reserves are destroyed, their services reduced. How does one balance these views? Or is health no different from any other part of the public budget, in that no one can claim to have the "right answer," no matter how apparently expert his work, and that the only way to decide is to strike a bargain among the competing claimants. Perhaps the principal pitfall in the politics of health-care cost containment is to think that it is different from any other form of politics.